ORM Corner

Communication an
A Lifesaving Combo

By Ltjg. Kent Jones

Our detachment was four months into a six-month WestPac. While in the Northern Arabian Gulf, our six pilots flew primarily at night. It was a rare occasion not to be flying or assigned landing-signal officer duties. We finally got into a routine, and I hoped to get on a normal sleep schedule. This, however, quickly changed.

Our ship's combat-systems officer (CSO) had a history of heart problems. He had seen a specialist in San Diego before deployment and was cleared to go. The stress of deployment and his job didn't seem to affect him, until one afternoon well into the cruise. The ship's senior corpsman, an experienced HMC, approached our detachment's officer in charge and told him the CSO was in the medical office. The CSO was complaining of a very sore chest and had difficulty breathing. Since the ship doesn't carry advanced heart-monitoring equipment, the senior medical officer, embarked on the carrier, recommended transporting him to a hospital. Isolated in the northern part of the gulf, we were too far away for a ship or RHIB transfer. Our choices were to medevac him that night or transfer him sometime the next day.

Although we did not know how critical the CSO's condition was, we looked into several options to medevac him that night. We checked with the maintenance officer and the chief if either aircraft could be ready to fly soon. We also made sure a crew was rested enough to make the flight.

We determined the nearest proper medical facility was in Bahrain. That hospital was 220 miles to the south but was closer than the carrier in our battle group, which was even farther south.

Now came the difficult decision. Our SOP states that flights from ship to shore shall not exceed 200 miles, and we were not authorized to take passengers at night. We looked into the possibility of using another ship as a lily pad where we would land, refuel and quickly take off again. We decided to keep this as our backup plan as these ships were not directly in our route of flight. We gathered the crew and had an ORM session. We considered the environmental conditions (night), fuel planning, and going to an unfamiliar airfield.

After discussing our options and making sure the entire crew was comfortable, we decided to fly the medevac. We also brought a hospital corpsman with us, in case of any in-flight medical emergencies. We made sure we had the flight

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Please send your questions, comments or recommendations to Ted Wirginis or to Capt. Denis M. Faherty, Director Operational Risk Management.

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charts and pubs, and we arranged for an ambulance to meet us at the Bahrain hangar. While this was going on, a small group of maintainers worked overtime to prepare a helicopter to fly on short notice.

We took off and had very favorable winds aloft, easily making the airfield with our patient in good health.

In hindsight, the decision to take this mission should have been easy. However, we had to consider all the factors involved because this would have been the perfect time for something to go wrong—while everybody was preparing to launch, or entering an unknown airfield in the middle of the night. What allowed everything to go smoothly and safely was good communication, use of operational risk management, and crew briefing. Everybody involved was informed: the three members of the flight crew, ship's personnel, our maintenance team, and even the LSO.

Ltjg. Jones flies with HSL-37.